STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
FACILITY LICENSING AND INVESTIGATIONS SECTION

IN RE: ADX LLC of Farmington, CT d/b/a
Lyon Manor
140 River Road
Willington, CT 06279

CONSENT ORDER

WHEREAS, ADX LLC of Farmington, CT (hereinafter the "Licensee"), has been issued License No. 1871 to operate a Residential Care Home known as Lyon Manor, (hereinafter the "Facility") under Connecticut General Statutes Section 19a-490 by the Department of Public Health, State of Connecticut (hereinafter the "Department"); and

WHEREAS, the Facility Licensing and Investigations Section (hereinafter the "FLIS") of the Department conducted unannounced inspections on various dates commencing on December 4, 2008 and concluding on December 8, 2008; and

WHEREAS, the Department, during the course of the aforementioned inspections identified violations of the Connecticut General Statutes and/or Regulations of Connecticut State Agencies in an amended violation letter dated December 15, 2008 (Exhibit A – copy attached); and

WHEREAS, the Licensee is willing to enter into this Consent Order agrees to the conditions set forth herein.

NOW THEREFORE, the FLIS of the Department acting herein and through Joan Leavitt its Section Chief, and the Licensee, acting herein and through Danyi Qian, its Owner/Person in Charge hereby stipulate and agree as follows:

1. Within thirty (30) days of the execution of this Consent Order the Person In Charge shall develop and/or review and revise, as necessary, policies and procedures related to medication administration, including but not limited to self-administration and resident rights.

2. Within ten (10) business days of completion of the review and revision to the aforementioned policies and procedures, all Facility staff shall be in-serviced regarding the policies and procedures identified in paragraph number one (1).
3. Effective upon the execution of this Consent Order, the Licensee, shall ensure substantial compliance with the following:
    a. Sufficient personnel are available to meet the needs of the residents;
    b. Medications are administered as prescribed by the physician and by appropriately credentialed personnel and/or through self administration by the resident;
    c. Resident rights are maintained;
    d. Staff receive the necessary required annual inservicing as per Regulations of Connecticut State Agencies for residential care homes;
    e. Compliance with all local and state building and fire safety codes;
    f. Water temperatures are monitored and maintained in a range not exceed 120°F in resident areas;
    g. An operational communication mechanism is in place;
    h. Reporting of unusual occurrences to the Department in accordance with applicable state regulations; and
    i. Job descriptions are reviewed and revised as appropriate and reviewed with each staff member to ensure that staff are providing the necessary care and services to the residents and within their scope of duties.
4. Within thirty (30) days of the execution of this Consent Order, the Facility shall contract with an Independent Consultant (IC) to review with the staff and management, the regulations and the facility's compliance with the regulations. This IC must have extensive experience in Residential Care Homes and must be approved by the Department. The IC's duties shall be performed by a single individual unless otherwise approved by the Department. The Licensee shall incur the cost of the IC. The IC shall function in accordance with the FLIS's INC Guidelines (Exhibit B – copy attached).
5. The IC shall be at the facility sixteen (16) hours per week for two (2) months at which time the Department will reevaluate the need for the continuation, increase, reduction or elimination of onsite time. The terms of the contract executed with the IC shall include all pertinent provisions contained in this Consent Order.
6. The IC shall act and perform the duties assigned herein at all times to serve the interest of the Department in assuring the safety, welfare and well-being of the residents and to

secure compliance with applicable federal, state and local law and shall not accept any direction or suggestion from the Licensee or its employees that will deter or interfere in fulfilling this obligation.

7. The IC shall conduct and submit to the Department an initial assessment of the Licensee's regulatory compliance and identify areas requiring remediation within five (5) weeks after the execution of this document.
8. The IC shall confer with the Licensee's Owner, Person in Charge and other staff determined by the IC to be necessary to the assessment of the Licensee's compliance with federal and state statutes and regulations.
9. The IC shall make recommendations to the Licensee's Person in Charge for improvement in the delivery of services provided to the residents. If the IC and the Licensee are unable to reach an agreement regarding the IC's recommendation(s), the Department, after meeting with the Licensee and the IC shall make a final determination, which shall be binding on the Licensee.
10. The IC shall submit weekly written reports to the Department documenting:
    a. The IC's assessment of the care and services provided to residents;
    b. The Licensee's compliance with applicable federal and state statutes and regulations; and
    c. Any recommendations made by the IC and the Licensee's response to implementation of the recommendations.
11. Copies of all IC reports shall be simultaneously provided to the Person in Charge and the Department.
12. The IC shall have the responsibility for:
    a. Monitoring and evaluating the delivery of services with particular emphasis and focus on residents rights, building and fire safety, medication administration and staffing;
    b. Recommending to the Department an increase in the IC's contract hours if the IC is unable to fulfill the responsibilities within the stipulated hours per week; and
    c. Monitoring the continued implementation of the Licensee's plan of correction submitted in response to the violation letter dated December 15, 2008 (Exhibit A).
13. The IC and the Licensee's Person in Charge shall meet with the Department every four (4) weeks for the first two (2) months after the effective date of this Consent Order and thereafter at six (6) weeks intervals throughout the tenure of the IC. The meetings shall

include discussions of issues related to the care and services provided by the Licensee and the Licensee's compliance with applicable federal and state statutes and regulations.

14. Any records maintained in accordance with any state or federal law or regulation or as required by this Consent Order shall be made available to the IC and the Department, upon request.
15. Within fifteen (15) days of the execution of this Consent Order, the Facility shall arrange a staff in service regarding residents' rights by an outside entity approved by the Department.
16. Effective upon the execution of this Consent Order, the Licensee shall ensure that all residents are afforded with care in a safe environment and at no time shall be placed in involuntary seclusion and/or physically restrained.
17. The facility shall contract with an outside vendor for the oversight of the water, fire-alarm and sprinkler systems.
18. The Licensee shall establish a staff development program with in-service programs scheduled at least four (4) times a year.
19. The Licensee shall make provisions for all applicable staff that participate in medication administration, to complete a medication administration course in accordance with applicable state regulations.
20. The Licensee shall notify the Department of any changes in personnel with regards to the Person In Charge.
21. The Licensee, within seven (7) days of the execution of this document, shall designate an individual within the Facility to monitor the requirements of this Consent Order. The name of the designated individual shall be provided to the Department within said timeframe.
22. The Licensee shall pay a monetary penalty to the Department in the amount of one hundred fifty dollars ($150.00), by money order or bank check payable to the Treasurer of the State of Connecticut and mailed to the Department within (2) weeks of the effective date of this Consent Order. The money penalty and any reports required by this document shall be directed to:

Cher Michaud, R.N., Supervising Nurse Consultant
Facility Licensing and Investigations Section
Department of Public Health
410 Capitol Avenue, P.O. Box 340308 MS #12HSR
Hartford, CT 06134-0308

23. All parties agree that this Consent Order is an Order of the Department with all of the rights and obligations pertaining thereto and attendant thereon. Nothing herein shall be construed as limiting the Department's available legal remedies against the Licensee for violations of the Consent Order or of any other statutory or regulatory requirements, which may be sought in lieu of or in addition to the methods of relief listed above, including all options for the issuance of citations, the imposition of civil penalties calculated and assessed in accordance with Section 19a-524 et seq. of the General Statutes, or any other administrative and judicial relief provided by law. This Consent Order may be admitted by the Department as evidence in any proceeding between the Department and the Licensee in which compliance with its terms is at issue. The Licensee retains all of its rights under applicable law.
24. The execution of this document has no bearing on any criminal liability without the written consent of the Director of the MFCU or the Bureau Chief of the Department of Criminal Justice's Statewide Prosecution Bureau.
25. The terms of this Consent Order shall remain in effect for a period of two (2) years from the effective date of this document unless otherwise specified in this document.
26. The Licensee understands that this Consent Order and the terms set forth herein are not subject to reconsideration, collateral attack or judicial review under any form or in any forum including any right to review under the Uniform Administrative Procedure Act, Chapter 368a of the Statutes, Regulations that exists at the time the agreement is executed or may become available in the future, provided that this stipulation shall not deprive the Licensee of any other rights that it may have under the laws of the State of Connecticut or of the United States.
27. The Licensee had the opportunity to consult with an attorney prior to the execution of this Consent Order.
28. Should the Licensee not be able to maintain substantial compliance with the requirements of the Consent Order the Department retains the right to issue charges to encompass the findings identified in the December 15, 2008 violation letter referenced in this document.

*

WITNESS WHEREOF, the parties hereto have caused this Consent Order to be executed by their respective officers and officials, which Consent Order is to be effective as of the later of the two dates noted below.

ADX LLC OF FARMINGTON, CT. d/b/a LYON MANOR

By: _____ 03/31/2009
Danyi Qian, Person in Charge

STATE OF Connecticut)

County of Hartford) ss Hartford 2009

Personally appeared the above named Danyi Qian, and made oath to the truth of the statements contained herein.

My Commission Expires: 04-31-2012
(If Notary Public)

_____
Notary Public [X]
Commissioner of the Superior Court [ ]

STATE OF CONNECTICUT,
DEPARTMENT OF PUBLIC HEALTH

March 31, 2009
Date

By: _____
Joan D. Leavitt, R.N., M.S., Section Chief
Facility Licensing and Investigations Section

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

EXHIBIT A
PAGE 1 OF 8

December 15, 2008

Danyi Qian, Administrator
Lyon Manor , Inc.
140 River Road
Willington, CT 06279

Dear Ms. Qian:

Unannounced visits were made to Lyon Manor, Inc. on December 4, 5 and 8, 2008 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting an investigation, a licensing inspection and a revisit for the purpose of reviewing care.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visits.

An office conference has been scheduled for December 18, 2008 at 10:00 A.M. in the Facility Licensing and Investigations Section of the Department of Public Health, 410 Capitol Avenue, Second Floor, Hartford, Connecticut. Should you wish legal representation, please feel free to have an attorney accompany you to this meeting.

Please prepare a written Plan of Correction for the above mentioned violations to be presented at this conference.

Each violation must be addressed with a prospective Plan of Correction which includes the following components:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Respectfully,

Cher Michaud R.N.

Cher Michaud, R.N.
Supervising Nurse Consultant
Facility Licensing and Investigations Section

CEM:lsl

CT #8898

Phone: (860) 509-7400
Telephone Device for the Deaf (860) 509-7191
410 Capitol Avenue - MS # 12HSR
P.O. Box 340308 Hartford, CT 06134
An Equal Opportunity Employer

DATES OF VISIT: December 4, 5 and 8, 2008 EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Connecticut General Statutes 19a –550 (b)(8)(c)(1) and/or Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (5).

1. Based on record review, a review of facility documentation, interviews with facility staff and observations, the facility failed to provide a safe environment for the residents. The findings include:
   a. Resident #1 was admitted to the facility 1/15/07. Diagnoses included Down's Syndrome and Dementia. Facility documentation identified that on 11/20/08 the door alarm sounded and resident eloped from the facility. Three staff persons attempted to reach him but the more they called him the faster he ran down the road. Staff eventually met up with the resident and Resident #1 was escorted back to the facility. On 11/22/08, a neighbor came to the facility to report that Resident #1 was down the road absent a coat or shoes. Staff Person #1 and Supervisor #1 accompanied the woman to escort the client to the facility. As they approached, Resident #1 started running and resisted returning to the facility. Interviews with facility staff identified that due to multiple episodes of unsafe behavior, the resident was being locked in his room to prevent him from eloping. Additionally, the facility failed to implement a system for monitoring the resident. On 12/4/08, during the inspection, the door was not locked. Facility staff including the owner, were advised that the facility needed to provide a safe environment without locking the resident in his room. On 12/8/08 at 8:50am, the resident's door was locked from the outside with the resident inside preventing the resident from exiting the room. On 12/8/08, an interview with Manager #2 identified that the door had been locked for approximately one hour. She was working in another hallway providing care to another resident and the other staff person on duty was in the kitchen. If there is nobody in the wing, they lock the door so the resident does not go out.
   b. On 12/4/08, an interview with the Owner/ Administrator identified that the facility was made aware of an allegation that Staff Person #7 had sold drugs to residents and was using marijuana with residents while working at the facility. Staff Person #7 denied the allegation. Subsequent to receiving the allegation, the facility conducted an investigation that resulted in multiple staff reporting that Staff Person #7 had used drugs while at work. On 12/10/08, during an interview, Staff Person #4 identified that she witnessed Staff Person #7 smoking out in the back of the facility with a resident. She was new at the facility and reported it to another Staff Person. One to two weeks later she was questioned by the Owner/Administrator and reported what she saw. Staff Person #7 was terminated from the facility 9/29/08.

DATES OF VISIT: December 4, 5 and 8, 2008

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (j) Attendants required (1).

2. Based on interviews and a review of facility documents, the facility failed to ensure adequate staffing. The findings include:
   a. The facility's licensed capacity is 36. The census at the time of inspection was 30. The Regulations of Connecticut State Agencies require 1 staff person for every 25 residents or part thereof. On 12/4 and 12/8/08, during interviews, the facility owner identified that due to various problems with personnel there have been occasions that there has been only one staff person on duty on the 11:00 pm to 7:00 am shift. Facility documentation for October 2008 to December 2008 failed to reflect that two staff persons were on duty on multiple occasions. On 12/10/08, during an interview, Manager #2 identified that the 10/4/08-10/24/08 schedule accurately reflected that there was only one person on duty on those dates. Interviews with multiple staff identified that routinely there was only 1 staff person on duty on the 11:00pm-7:00 am shift and that this had occured as far back as July 2008.

The following is a violation of the Connecticut General Statutes 19a-550 (b)(2) and/or Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (1).

3. Based on observation, review of facility documentation and interview with facility staff, the facility failed to protect the resident's rights. The findings include:
   a. Documentation was lacking to reflect that the residents had been fully informed prior to or at the time of admission and during their stay at the facility of the services and related charges including any charges not included in the basic per diem rate. The facility lacked documentation that identified what was included in the daily room rate. On 12/8/08, during an interview, the owner identified that she had implemented a new "fine" for residents that have excessive electronic equipment or excessive items to store. There was no documentation available identifying the fee. The owner further identified that she had warned the residents for a long time that they would be fined for items but had just implemented the fines this December. Three residents had been fined, Resident #2, #5 and #9. Resident #9 was fined because he had too many bags of clothing. Resident #2 was fined because of the extension cord and extra electronic equipment and Resident #5 because of an extension wire. Interviews with residents identified that they were fined after the inspection on 12/4/08 because they had power strips/extension cords in their rooms.
   b. The resident Bill of Rights had not been posted in a conspicuous area of the facility.

DATES OF VISIT: December 4, 5 and 8, 2008

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (m) Administration of Medication (2)(E) and/or (F).

4. Based on interviews with facility staff and residents, a review of resident records and facility documentation, the facility failed to ensure that medications were only administered by medication certified staff and /or are documented accurately and/or that medications were stored in their original containers. The findings include:
   a. On 12/8/08, tours of the medications room identified multiple "baggies" labeled with resident's names and times. On 12/08/08, during an interview, Manager #2 who is certified to administer medication identified that she pre-pours the medications on the day shift for the medication passes on the other shifts so that if she can't come in to administer medications when non-medication staff are on duty then the non-medication certified staff can administer the pre-poured medications. Interviews with multiple staff identified that non-medication certified staff routinely administer medication for the 3:00-11:00pm and the 11:00 pm- 7:00am shifts. Manager #2 prepares the medications in "baggies" to be administered by them. Additionally, Manager #2 often signs the prepared medications off as administered.
   b. Resident #2, #3, #6's medication administration records for November 2008 included multiple medication omissions for the 3:00-11:00pm shift on 11/17, 21, 22, 23, 28, 29 and 30. On 11/21,11/22,11/28,11/29/08 Staff Person #4 and #5, who lack medication certification, were the only staff scheduled on duty. Interviews with staff identified that Staff Person # 4 administered the pre-poured medications on those days. On 12/10/08, during an interview, Manager #2 identified that the residents definitely received their medications on the dates with omissions/no initials. If she pre-pours the medications she generally signs them off as given and she must have forgotten to chart on those dates. Non-medication certified staff do not chart medications.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (m) Administration of Medications (2)(D)(i) and/or (ii).

5. Based on observations, record reviews and interviews with facility staff the facility failed to ensure that the medications administered were consistent with the directions on the package/blister pack and that all medication orders were in writing from an authorized prescriber. The findings include:
   a. Resident #3 was admitted to the facility 8/31/04. On 12/4/08 during the morning medication pass the resident received, in part, Trazadone 50mg and Zyprexa 20mg. The respective blister packs identified the following Trazadone 50 mg one tablet at bedtime for sleep may repeat one time as needed for sleep and Zyprexa 20mg at bedtime. On 12/4/08, during an interview, Manager #2 identified that the physician gave her orders over the phone a while ago to change the times of the medications. She was not sure of the date. She did not receive any new written orders. She routinely takes orders over the phone and was not aware that she was not able to do so. The November and December

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

typed medication records reflected the following Trazadone 50 mg one tablet at bedtime for sleep, may repeat one time as needed for sleep however the times of administration were noted as 9:00am and 9:00pm. The November medication record identified Zyprexa 20 mg by mouth other directions had been written over rendering them illegible and 9:00am was hand written in as time of administration. The December 2008 medication record identified Zyprexa 20 mg at bedtime with 9:00 am written in as time of administration. The facility policy for administration of medications identified that medication certified staff will not accept telephone orders. All orders are to be in writing.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (4)(B).

6. Based on a review of personnel files, facility documentation and interviews with facility staff, the facility failed to maintain documentation to reflect that up to twelve hours of continuing education was provided to staff. The findings include:
    a. Seven of seven personnel files reviewed of staff that had been employed more than one year lacked documentation that up to twelve hours of continuing education had been provided to staff. Facility documentation identified 7 hours of staff continuing education in 2005 inclusive of the medication certification course, additionally the owners and Manager #1 took a food safety course in 2005. Three hours of continuing education was documented in 2007 and 4 hours in 2008. On 12/8/08, during an interview, Manager #1 identified that they were short on the required in-service hours. Additionally, the available documentation failed to reflect that the staff had received annual continuing education related to resident's rights, nutrition, food safety and personal care.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration (4).

7. Based on personnel file reviews and interviews with facility staff, the facility failed to ensure that pre-employment references had been conducted and/or that annual performance evaluations had been conducted. The findings include:
    a. Although consent for background checks had been granted, documentation was lacking that pre-employment reference checks had been obtained for 6 of 6 staff reviewed that were hired in 2007 and 2008. On 12/8/08, during an interview, the owner/administrator identified that she obtained some information verbally but didn't document it. She also stated that people usually will not give references.
    b. Documentation was lacking that annual evaluations had been conducted in 2006, 2007 or 2008, as appropriate, for 7 of 7 staff reviewed that had been employed by the facility for greater than one year. On 12/4/08 during an interview the owner/administrator identified that she did them but could not locate them.

DATES OF VISIT: December 4, 5 and 8, 2008 EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Connecticut General Statutes 19a-493 and/or Regulations of Connecticut State Agencies Section 19-13-D6 (c) Administration.

8. Based on tours of the facility and interview with facility staff, the facility failed to post the license to operate the facility. The findings include:
   a. Tours of the facility on 12/4/08 identified that the license was not posted. On 12/4/08, during an interview the Owner/Administrator identified that she was unable to locate the license.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (b) Physical Plant (A)(2)(b) and/or (O)(2).

9. Based on tours of the facility, a review of facility documentation and interviews with facility staff, the facility failed to ensure compliance with the Connecticut Fire Safety Code and/or NFPA and/or ensure proper functioning of the emergency generator. The findings include:
   a. Documentation was lacking that fire drills were conducted on each shift with at least 2 held during sleeping hours. All the fire drills conducted for 2007and 2008 were conducted on the 7:00am to 3:00pm shift.
   b. Documentation was not provided that the automatic sprinkler system was inspected in the fourth quarter of 2007 and the first quarter of 2008.
   c. Documentation was not provided that the emergency generator was serviced the second half of 2006 or at all during 2007 and 2008. The last service date was 1/13/06. On 12/8/08, during a test of the generator the transfer time was noted to be 14 seconds exceeding the required interval of ten seconds. The facility lacked any documentation of the transfer times. On 12/08/08 during an interview, Manager #1 identified that the generator tested itself automatically and the available documentation reflected that staff heard the generator turn on. Staff is not in attendance at the generator during testing.
   d. During a tour on 12/4/08 an "Oxygen in use: NO smoking" sign was not posted at room four where oxygen was in use.
   e. An extension cord and/or power strip were observed in use in resident room four, resident room twelve and the lobby.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (b) Physical Plant (H)(5) and/or (c) Administration (1) and/or (5).

10. Based on observation of the kitchen, the facility lacked a stove extinguishing system. The findings include:
    a. Tours of the kitchen, on 12/4/08 identified that the stove lacked a fire extinguishment system. On 12/11/08, during an interview, Manager #2 identified that this was the same stove that was at the facility prior to the 2005 change of ownership.

DATES OF VISIT: December 4, 5 and 8, 2008 EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (b) Physical Plant (M)(4)(b)(7) and/or (c) Administration (1) and/or (5).

11. Based on tours of the facility, the facility failed to maintain hot water temperatures between 110-120 degree Fahrenheit at fixtures intended for resident use. The findings include:
    a. Hot water at plumbing fixtures intended for resident use exceeded 120 degrees F on 12/4/08 as follows:
        i. 128 degrees in Men's shower room at 2:25pm.
        ii. 35.7 degrees in Room 28 at 240pm.
        iii. 145.7 degrees in the second floor shower room at 3:15pm.
        iv. 130.8 degrees in Room 13 (bathroom off room 27) at 3:20pm.
        v. A review of facility documentation identified the last water temperature prior to 12/4/08 on an unidentified day in November 2008 the was 126 degrees in the men's shower room with a notation that it was fixed.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (b) Physical Plant (H)(4) and (f) Dietary Service (4) and/or (c) Administrator (1) and/or (5).

12. Based on tours, a review of facility documentation and interviews, the facility failed to ensure that the dishwasher was operational. The findings include:
    a. Observation of the dishwasher identified a chemical sanitizing unit. Information on the unit identified the wash temperature should be 120 degrees and the chemical sanitizer should reach 50 ppm (parts per million) available chlorine. On 12/4/08 the wash temperature was 126 degrees but the test strip registered no color change (no ppm of chlorine). Observations identified that although the sanitizer reservoir was full there was no solution coming through the tubing.
    b. A review of the dishwasher testing documentation identified that it had last been tested 11/27/06. On 12/4/08, during an interview, Manager #1 could not identify when the dishwasher had last been checked although she thought it was being done weekly by another staff member.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (b) Physical Plant (N)(5).

13. Based on tours of the facility, it was observed that a fully operational communication system was not in place. The findings include:
    a. On 12/8/08 the second floor communication system failed to activate an audible and visual signal at the designated station across from the kitchen for resident rooms 26 and

DATES OF VISIT: December 4, 5 and 8, 2008

EXHIBIT A

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

27 on the second floor. On 12/8/08, during interview Manager #1and #2 identified that they were not aware that it was not working.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (b) Physical Plant (Q).

14. Based on tours of the facility, the facility failed to ensure that the room capacity was posted for all rooms. The findings include:
    a. The room capacity was not posted for resident rooms #4, #14 and #15.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (c) and/or Administration (1) and/or (5) and/or (h) General Conditions (3).

15. Based on interview and a review of facility documentation, the facility failed to report an unusual occurrence to the Department. The findings include:
    a. Facility documentation identified that on 11/22/08 a neighbor reported to facility staff that a resident was observed on Rt. 32 without shoes or a coat. Resident #1 was not permitted to be out unattended. The resident had to be fought with to get him into the car to return. On 12/4/08, during an interview, Manager#1 identified that the facility did not notify the Department.

The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D6 (h) General Conditions (6).

16. Based on tours of the facility and interviews with facility staff, the facility failed to ensure that adequate housekeeping and /or maintenance services were provided. The findings include:
    a. The wallpaper and/or paint was noted to be peeling or marred in the following areas: rooms 19,16 and 28, the men's shower room, the hallway outside room 26, the inside smoking porch, the front outside porch, administrator's office, the dining room and the exterior of building in multiple areas.
    b. There were stained ceiling tiles in rooms 7 and 19.
    c. The ceiling light was not securely attached in room 10.
    d. There was a void in the wall around the electrical outlet in the living room and void in the ceiling and missing sheet rock in the ceiling in the dining room.
    e. The metal decorative railing on the front porch was rusting.
    f. There were 4 damaged floor tiles near the dining room/bathroom in the hallway, cracked/missing floor tiles and rusted radiator cover in the bathroom by the dining room.
    g. The outside of the water cooler was rusted.
    h. There were multiple brown stains on the floor in the 2nd floor shower room.
    i. There were 2 broken floor tiles near the women's bathroom on the 1st floor.
    j. The windows in the living room were soiled.

EXHIBIT B
PAGE 1 OF 1

FLIS Independent Nurse Consultant Guidelines

Relationship between Independent Nurse Consultant (INC) and DPH includes:

- An INC is utilized as a component of DPH's regulatory remedy process. An INC may be agreed upon as a part of a Consent Order between the institution and the Department when significant care and service issues are identified.
- The INC has a fiduciary or special relationship of trust, confidence and responsibility with the Department.
- The INC's responsibilities include:
  - Reporting to the Department issues and concerns regarding quality of care and services being provided by the institution.
  - Monitoring the institution's plan of correction to rectify deficiencies and violations of federal/state laws and regulations. Reports to Department positive and negative issues related to said oversight.
  - Assessing administration's ability to manage and the care/services being provided by staff.
  - Weekly reporting to the Department of issues identified, plans to address noncompliance and remediation efforts of the institution.

Relationship between INC and the Institution:

- The INC maintains a professional and objective relationship with the institutional staff. The INC is a consultant, not an employee of the institution. The INC exercises independent judgment and initiative to determine how to fully address and complete her/his responsibilities. The institution does not direct or supervise the INC but must cooperate with and respond to requests of the INC related to her fulfilling her/his duties.
- The INC's responsibilities include:
  - Assessment of staff in carrying out their roles of administration, supervision and education.
  - Assessment of institution's compliance with federal/state laws and regulations.
  - Recommendations to institutional administration regarding staff performance.
  - Monitoring of care/services being provided.
  - Assists staff with plans of action to enhance care and services within the institution.
  - Recommendation of staff changes based on observations and regulatory issues.
  - Weekly reports to the institution re: assessments, issues identified, and monitoring of plans of correction.
  - Promotes staff growth and accountability.
  - May present some inservices but primary function is to develop facility resources to function independently.
  - Educates staff regarding federal/state laws and regulations.